U.S. Department of Labor

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Issue Date: 31 May 2007

Case No.: 2006-BLA-05569

In the Matter of

J. J.
Claimant

v.

U. S. STEEL MINING COMPANY, LLC
Employer

and

SELF-INSURED THROUGH
UNITED STATES STEEL CORP.
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

Appearances: PATRICK NAKAMURA, Esq. For the Claimant
JAMES N. NOLAN, Esq. For the Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was

due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On April 14, 2006, this case was referred to the Office of Administrative Law Judges for a formal hearing (DX 27).[1] Subsequently, on May 4, 2006, the case was assigned to me. The hearing was held before me in Birmingham, Alabama, on September 26, 2006, at which time the parties had full opportunity to present evidence and argument.

The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication:[2]

(1) whether the Claimant suffers from pneumoconiosis;
(2) whether his pneumoconiosis, if any, arose from coal mine employment;
(3) whether the Claimant is totally disabled; and
(4) whether the Claimant's total disability, if any, is due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on May 16, 2005 (DX 3). On February 9, 2006, the District Director issued a proposed Decision and Order awarding benefits to the Claimant (DX 23). The Employer requested a formal hearing, and the matter was referred to the Office of Administrative Law Judges on April 14, 2006 (DX 27).

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in July of 1942. Currently, he has no dependents (DX 3). The Claimant worked in coal production for 30 years, largely underground and at the face of the coal (See T. at 19-33).

B. Claimant's Testimony

The Claimant testified under oath at the hearing. He stated that his coal mine employment started in November 1973, when he worked for the Concord mine. During his career, he held several positions, such as rock man helper, shot firer, shuttle car operator, roof

[1] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "T." refers to the transcript of the September 26, 2006 hearing.

[2] The parties stipulated to 30 years of coal mine employment (T. at 17). I find that the record supports this stipulation.

bolter, and face man on the belt line. He testified that generally, he worked at the face of the coal, and the work was dusty. He also testified that, at the time he left the mines, he was having breathing problems, especially upon exertion (T. at 19-33).

The Claimant stated that he started smoking in about 1957, when he was 15 years old, but that he quit in 1994 after a heart attack, and that after he stopped smoking, his breathing did not improve. He testified that he smoked about a pack per day. He also stated he uses a machine to inhale medication for his breathing. Further, he stated that he continues to have heart problems, and currently is on dialysis. Finally, the Claimant stated that has never made a claim related to asbestos (T. at 33-39).

On cross examination, the Claimant affirmed that most of the time, he does not have too much trouble with his breathing, but he does have trouble after a little bit of exertion (T. at 40-41).

Upon my questioning, the Claimant stated that his breathing problems may have started about three years before he retired, and that he was never moved to another job due to his breathing problems. He testified that he gained a lot of fluid weight related to his kidney dialysis, and that he is currently supposed to monitor his fluid (T. at 41-43).

C. Relevant Medical Evidence

The Claimant presented several chest X-ray interpretations, one from Dr. Ballard, one from Dr. Cappiello (DX 11, 12) and two rebuttal readings from Dr. Miller (DX 12, CX 2).[3] The Claimant also submitted treatment notes and a consultation report from Dr. Jeffrey Hawkins[4](CX 1).

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[3] The treatment records at CX 1 include narrative X-ray reports, however, I consider these interpretations as part of the treatment notes, and not as the Claimant's X-ray interpretations.

[4] Dr. Hawkins also performed the OWCP evaluation. During the adjudication of this claim, an issue arose concerning the start date of Dr. Hawkins' treatment of the Claimant, specifically, whether the treatment started before or after the OWCP evaluation, which would impact on whether the OWCP evaluation was conducted in compliance with § 725.406. On March 23, 2007, I issued an Order requiring the Claimant to submit, within thirty days, an affidavit attesting to: 1) the nature and extent of Dr. Hawkins' medical treatment, and 2) the specific date on which Dr. Hawkins started treating the Claimant. On April 16, 2007, I received the Claimant's affidavit. In that affidavit, the Claimant testified that the first time he was examined or treated by Dr. Hawkins was on July 22, 2005, the date of the OWCP evaluation, and that after that examination, he decided to use Dr. Hawkins as a treating physician, and he has seen him on several occasions since. The Claimant stated that "Dr. Hawkins did not examine me or provide any medical treatment to me within the twelve months preceding the date (4/25/05) I filed my application for benefits in this case." In addition, the Claimant testified that "[t]he reference to the date '04/19/2005' reflected in Dr. Randy Finley's x-ray report is an error." Based on the evidence of record, including responses to my March 23 order and Claimant's affidavit, I find that § 725.406(b) was not violated.

The Employer presented chest X-ray interpretations from Dr. Goldstein and Dr. Wiot (EX 1, 3); Dr. Goldstein also performed a pulmonary function study and a blood gas study (EX 1). In addition, the Employer presented medical reports from Dr. Goldstein and Dr. Rosenberg (EX 1, 5). The curriculum vitae of Dr. Goldstein, Dr. Wiot and Dr. Rosenberg were also submitted by the Employer (EX 2, 4, 6).

Dr. Hawkins performed the OWCP evaluation, which included Dr. Ballard's chest X-ray interpretation (DX 11).

These items will be discussed in greater detail below.

D. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory, or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. Further, § 718.201(b) states: "a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).

(3) Regulatory presumptions: § 718.202(a)(3).[5]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

1) X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102 may form the basis for a finding of the existence of pneumoconiosis. ILO Classifications 1, 2, 3, A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

The current record contains the following chest X-ray evidence:

Date of X-Ray	Date Read	Ex. No.	Physician	Radiological Credentials[6]	Interpretation
07/22/2005	08/02/2005	DX 11	Ballard[7]	BCR	1/0, s, t, all six zones
07/22/2005	09/29/2005	DX 12	Cappiello	BCR, B reader	1/0, p, q, all six zones

[5] These are as follows: (a) an irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[6] A physician who is a Board-certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1. A B reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program.

[7] Dr. James Ballard performed the X-ray interpretation in conjunction with the Claimant's OWCP evaluation. Under cover dated October 20, 2006, the Employer made a Motion to Exclude Opinions Or Reports Authored By Dr. James Ballard. In support of its Motion, the Employer stated that a lawsuit was brought against Dr. Ballard alleging that he performed fraudulent X-ray readings, in conjunction with other litigation. As the readings in question are not part of the matter before me, I do not find that Dr. Ballard's reading in this matter should be disregarded. However, in light of the above, I will give his reading less weight than I would otherwise. In addition, I note that regarding the July 2005 X-ray that he read, I find that the remaining interpretations of the same X-ray would weigh in favor of finding the evidence positive for pneumoconiosis. Specifically, I note that two dually qualified physicians also interpreted this X-ray as positive for pneumoconiosis.

07/22/2005	10/03/2005	DX 12	Miller	BCR, B reader	1/0, q, p, all six zones
07/22/2005	10/25/2005	EX 2	Wiot	BCR, B reader	Negative
11/22/2005	11/22/2005	EX 1	Goldstein	B reader	Negative
11/22/2005	10/16/2006	CX 2	Miller	BCR, B reader	1/0, q, t, all six zones

It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984).

Where two or more X-ray reports conflict, consideration shall be given to the radiological credentials of the physicians interpreting the X-rays. § 718.202(a)(1). It is well established that the interpretation of an X-ray by a B reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B reader may be given more weight than that of a physician who is only a B reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

For the purpose of determining the X-ray evidence, I give more weight to the opinions of physicians who are Board-certified radiologists and B readers than I do to the opinions of physicians who are not Board-certified radiologists but are B readers. I give more weight to the opinions of the former because they have wide professional training in all aspects of X-ray interpretation. I give equal weight to all physicians who possess the same professional credentials (for example, all Board-certified radiologists).

As listed above, the record contains six interpretations in total; four interpretations of the first X-ray dated 07/22/2005, and two interpretations of a second X-ray dated 11/22/2005.[8] In this case, there is conflict regarding both X-rays.

The July 2005 X-ray was interpreted as positive for pneumoconiosis by three Board-certified radiologists, two of which are also B readers; and was also interpreted as negative by

[8] Dr. Hawkins' treatment records include narrative X-ray reports, however, I consider those X-rays as part of treatment, and I did not evaluate them as part of the X-ray evidence. In addition, the qualifications of the readers are not of record. In sum, therefore, I give these readings no weight.

one physician who is dually qualified. I find that the three positive readings of the July 2005 X-ray outweigh the one negative reading, and therefore, I find that this X-ray provides evidence of pneumoconiosis. Concerning the November 2005 X-ray, it interpreted as positive by a dually-certified physician, and interpreted as negative by a physician who is qualified as a B reader only. As the positive reading was performed by the more qualified physician, I find that this X-ray is also illustrative of pneumoconiosis.

Therefore, I find that the Claimant is able to establish pneumoconiosis by X-ray.

2) Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

3) Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Because none of these presumptions applies in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

4) Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989). Generally, a medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields, supra. An opinion based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985).

The record contains the following medical opinions:

Dr. Jeffrey Hawkins (DX 11, CX 1)

Dr. Hawkins performed the OWCP sponsored evaluation of the Claimant in July 2005. In conjunction with this examination, an X-ray, a pulmonary function test, and an arterial blood gas test were produced. In addition, Dr. Hawkins took the Claimant's medical history, attached a copy of his employment history to the form, and performed a physical examination. Dr. Hawkins is Board certified in internal medicine, pulmonary medicine, and critical care; he is also a Diplomate of the National Board of Medical Examiners.

Concerning the Claimant's reported physical condition, Dr. Hawkins noted his kidney failure and dialysis treatment. He noted sputum, exterional wheezing, dyspnea, occasional cough, orthopnea, and ankle edema. Dr. Hawkins also noted that the Claimant started smoking cigarettes at age 15, and stopped smoking in December 1994; he smoked one pack per day.

Upon physical examination of the lungs and thorax, Dr. Hawkins noted that they were symmetrical upon inspection, with no lesions; palpatiation was non-tender; percussion showed no dullness, and auscultation increased time for expiration.[9] The Claimant's extremities showed no cyanosis, clubbing, varicosities, and ankle edema.

Dr. Hawkins also summarized the diagnostic testing. The chest X-ray showed "parenchymal changes consistent with pneumoconiosis."[10] The pulmonary function studies showed "mild airflow obstruction/moderate ventilatory defect." The arterial blood gas showed "adequate resting & exertional gas exchange."

Dr. Hawkins' diagnoses were as follows: pneumoconiosis shown by dyspnea, ABN CXR/ABN spirometry, due to coal mine environment and dust; COPD/chronic bronchitis shown by dyspnea, cough, sputum and wheeze, due to cigarette smoking and coal mine exacerbation; and CAD, history of MI, due to arteriosclerosis and coronary artery disease.

As discussed above, after performing the OWCP evaluation, Dr. Hawkins began working as the Claimant's treating physician. The Claimant submitted treatment notes from Dr. Hawkins, which include a clinical consultation report on April 19, 2006, as well as handwritten treatment notes dated September 22, 2005, a sleep study report dated December 14, 2005,[11] and chest X-ray reports.

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[9] I note some difficulty in reading the handwriting on the report.

[10] Dr. Ballard's August 2, 2005 X-ray interpretation is included as part of the OWCP evaluation, and the report states that the examination was performed on July 22, 2005. Further, the handwritten date stating when the report was written is not clear, but it appears that the date reads, August 10, 2005. The report was received by the Director on August 15, 2005. Therefore, based on these facts, although Dr. Hawkins did not state which X-ray he used in his evaluation, I presume that he was referring to Dr. Ballard's X-ray.

[11] Although the sleep study report is included in the record, the handwriting is difficult to read, and therefore, the notes are of little value to my evaluation.

The records regarding the Claimant's April 2006 visit make several observations about the Claimant's status. Concerning his chest, the notes state "[r]eveals bilateral breath sounds, which were moderately reduced throughout. There was increased expiratory time." The cardiovascular exam revealed "regular rate and rhythm with no murmurs or gallops. There are no carotid bruits." His extremities showed "1+ edema at the ankles bilaterally." Finally, Dr. Hawkins' assessment was stated as follows:

1. Respiratory insufficiency/coal worker's (sic) pneumoconiosis/chronic obstructive pulmonary disease – chronic bronchitis. [The Claimant] is very limited regarding respiratory status. He is at baseline without any further deterioration. Chest x-ray demonstrated no change in the small right mid lung pulmonary nodules.
2. Obstructive sleep apnea syndrome. [The Claimant] is using C-PAP on a nightly basis. He tolerates this well, and it is effective. [The Claimant] is well-rested in the morning and alert throughout the daytime.
3. Coronary artery disease. [The Claimant] is hemodynamically stable today. He had one episode of mild discomfort with moderate exertion, though no other episodes. He will continue current medication.
4. [The Claimant] will return to clinic in four months.

Dr. Allan Goldstein (EX 1, 2)

Dr. Goldstein evaluated the Claimant in November 2005, and wrote a report stating his conclusions. His examination included a chest x-ray, pulmonary function test, arterial blood gas test; he also took a medical and work history. Dr. Goldstein is Board-certified in internal medicine and pulmonary disease; he is also a certified B reader. In addition to his evaluation and written report, Dr. Goldstein also testified by deposition, where he reiterated his opinion on the Claimant's condition.

Concerning the Claimant's occupational history, Dr. Goldstein noted that the Claimant worked in the coal mines from 1973 until 2004; he worked "underground as a general inside laborer," and also "worked as a roof bolter and ran a shuttle car." Dr. Goldstein also stated that the Claimant was exposed to "coal dust, rock dust and diesel fumes," but "[h]e did wear a mask."

Upon physical examination of the chest, he noted that the chest was "[c]lear to percussion and auscultation." He also noted that the Claimant's extremities demonstrated "[n]o cyanosis, clubbing or edema."

Concerning the X-ray and laboratory results, Dr. Goldstein stated the following:

> PA and lateral chest x-rays show the heart to be enlarged. The lung fields are small. There is no evidence of interstitial disease or nodules. Complete pulmonary functions suggest a restrictive defect with the possibility of some obstruction. There is no response to bronchodilators. The diffusion capacity is reduced but normalized for alveolar volume. EKG shows T wave abnormalities suggestive of ischemia. There are changes from V1 to V3 consistent with an old anterior myocardial infarction….

Dr. David Rosenberg (EX 5, 6)

At the request of the Employer, Dr. Rosenberg wrote a consultative report in August 2006, after reviewing several pieces of evidence. Specifically, he reviewed 1) Dr. Hawkins' July 22, 2005 evaluation, 2) B readings of the July 22, 2005 X-ray, by Dr. Wiot, Dr. Miller, Dr. Cappiello, Dr. Barrett,[12] and Dr. Ballard, 3) the July 22, 2005 pulmonary function tests by Dr. Michos, and 4) Dr. Goldstein's evaluation of November 22, 2005. Dr. Rosenberg is Board-certified in internal medicine, pulmonary disease, and occupational medicine.

After reviewing and summarizing the evidence, Dr. Rosenberg stated the following:

> [I]t can be appreciated that [the Claimant] has a moderate degree of restriction based on his decreased total lung capacity. This is associated with a normal diffusing capacity corrected for lung volumes, which supports the fact that he has "extrinsic" and not "intrinsic" restriction. If he truly had a parenchymal lung problem accounting for this restriction (intrinsic), then one would have expected an associated very significant decrement of the diffusing capacity corrected for lung volumes. Such was not the case. Also, chronic rales were not heard on auscultation. In addition, his x-rays have variably been read as demonstrating either some low-grade micronodularity related to past coal dust exposure or as being normal. In fact the more recent B reading of Dr. Goldstein (November 22, 2005) was 0/0 for the presence of pneumoconiosis. It should be emphasized, if one truly had pneumoconiosis, one would expect persistent chest X-ray abnormalities and not something that dissipates over time. Also, it should also be appreciated that [the Claimant] is on peritoneal dialysis for chronic renal failure. This has major implications with respect to his pulmonary function. When an individual is undergoing peritoneal dialysis, fluid (dialysate) is infused into the abdomen in order to remove impurities from the blood stream. This peritoneal fluid accumulates in the abdomen and obviously impairs diaphragmatic function leading to restriction. In addition, it causes ventilation/perfusion mismatch, causing an oxygenation abnormality. Also, dialysis in conjunction with renal failure commonly is associated with fluid overload and the presence of heart failure. This obviously can also lead to interstitial changes on X-ray. Under the circumstances, with respect to [the Claimant], with moderate restriction being present, coupled with his variable B Readings (most recent film being 0/0), and a normal diffusing capacity corrected for lung volumes, with reasonable certainty [the Claimant] does not have clinical coal worker's (sic) pneumoconiosis (CWP)….
>
> In conclusion, it can be stated with a reasonable degree of medical certainty that [the Claimant] does not have medical or legal coal worker's (sic) pneumoconiosis (CWP).

[12] Dr. Barrett performed the quality re-reading of the OWCP X-ray on August 22, 2005.

Discussion

The record contains three physician opinions; Dr. Hawkins, who opined that the Claimant had pneumoconiosis, and Dr. Goldstein and Dr. Rosenberg, who opined that the Claimant did not have pneumoconiosis.

Dr. Goldstein and Dr. Rosenberg both based their opinions on an assumption that X-ray evidence, particularly Dr. Goldstein's X-ray reading, did not show pneumoconiosis. However, as discussed above, I have found that the X-ray evidence as a whole, as well as the particular X-ray read by Dr. Goldstein, are both demonstrative of pneumoconiosis. Furthermore, it appears that Dr. Rosenberg did not appreciate that pneumoconiosis can be present in the absence of X-ray findings, as he stated that "if one truly had pneumoconiosis, one would expect persistent chest X-ray abnormalities." Therefore, as these opinions were based on an understanding of the X-ray evidence that is contrary to my finding, or on a possible misunderstanding of the regulations, I give little weight to their opinions. In contrast, Dr. Hawkins' opinion is consistent with my own findings on the X-ray evidence, and appears to be based on a thorough understanding of the Claimant's condition, as well as on the relevant regulatory requirements. For those reasons, I give significant weight to Dr. Hawkins' opinion.

After considering this evidence, I find that the Claimant has established by physician opinion, that he has pneumoconiosis.

Based on the foregoing, I find that the Claimant has established, by a preponderance of the evidence, that he has pneumoconiosis. My finding is based upon the weight of the medical evidence contained in the record of this case.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). However, where a miner has established less than ten years of coal mine employment history, "it shall be determined that such pneumoconiosis arose out of that employment only if competent evidence establishes such a relationship." § 718.203(c).

In this case, the parties have stipulated that the Claimant has 30 years of coal mine employment. Therefore, he is entitled to the rebuttable presumption, and as the employer has not presented evidence necessary to counter this presumption, I find that the Claimant has established, by a preponderance of the evidence, that his pneumoconiosis arose out of his coal mine employment.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) from performing his or her usual coal mine work; or (ii) from

engaging in gainful employment . . . requiring the skills and abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. § 718.204(a). See also Beatty v. Danri Corp., 16 B.L.R. 1-11 (1991).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

1) Pulmonary Function Tests

A Claimant may establish total disability based upon pulmonary function tests. In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.204(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The record contains the following pulmonary function test results:

Date of Test	Physician	Height	FEV_1	FVC	MVV	FEV_1/FVC ratio	Valid ?
07/22/2005	Hawkins	68	1.32	1.81	63	73	Yes
11/22/2005	Goldstein	66	1.36/1.30*	1.77/1.67	56/56	77/78	Yes[13]

* The second set of numbers was produced after bronchodilator.

The Claimant was born in July of 1942, so he was 62 years old, and 63 years old at the time these tests were performed. His height was listed at 66 inches, and 68 inches; I find that he is 67 inches tall, which is the average of the two listed heights.

For a 62 year old male, who is 66.9 inches tall, the qualifying FEV_1 value is 1.78, the qualifying FVC value is 2.28, and the qualifying MVV value is 71. For a 63 year old male, who is 66.9 inches tall, the qualifying FEV_1 value is 1.76, the qualifying FVC value is 2.26, and the qualifying MVV value is 70.

[13] However, I note that the record does not include original tracings.

All of the Claimant's pulmonary function studies produced qualifying results. Therefore, I find that the Claimant is able to establish total disability under this provision.

2) Arterial Blood Gas Tests

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

The record contains the following arterial blood gas test results:

Date of Test	Physician	PCO_2	PO_2	PCO_2 (post-exercise)	PO_2 (post-exercise)	Altitude
07/22/2005	Hawkins	43	86	43	79	0-2999 feet above sea level
11/22/2005	Goldstein	40	68	N/A*	N/A*	N/A[14]

* post exercise trials not performed.

For a PCO_2 value between 40 and 49, at an altitude of 2999 feet or less, the qualifying PO_2 value must be equal to or less than 60. Neither of the Claimant's arterial blood gas studies produced qualifying results.

Therefore, I find that the Claimant is unable to establish total disability under this provision.

3) Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). However, there is no evidence of cor pulmonale with right-sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

4) Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Fields v. Island Creek Coal Co.,

[14] Per 29 C.F.R. § 18.201, judicial notice may be taken of adjudicative facts. The highest point in Alabama is 2,407 feet. See http://geology.com/states/alabama.shtml.

10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id. An unreasoned or undocumented opinion may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 BLR 1-149, 1-155 (1989). A physician's opinion must demonstrate an adequate understanding of the exertional requirements of the Claimant's coal mine employment. Brigance v. Peabody Coal Co., B.R.B. No. 05-0722 B.L.A. (June 29, 2006)(en banc).

Dr. Jeffrey Hawkins (DX 11, CX 1)

Dr. Hawkins opined that the Claimant had a moderate/severe respiratory impairment, as he is "unable to perform manual labor or last coal mine job." He recommended that the Claimant "avoid chemicals, dust, fumes." He attributed the Claimant's impairment to the following: 50% to pneumoconiosis, 40% to COPD, and 10% to CAD.

Dr. Allan Goldstein (EX 1, 2)

Concerning impairment, Dr. Goldstein stated the following:

> [The Claimant] has had progressive shortness of breath for 10 to 15 years. He had a cough that improved after he quit smoking. He does have renal failure and is on peritoneal dialysis. He has an enlarged heart. He has gained 50 pounds since he left work. His pulmonary functions are restrictive and are most like (sic) related to his body stature. He does have some hypoxia that can be explained by his body stature.
>
> The patient's chest x-ray does not explain a restrictive defect. In individuals with coal workers' pneumoconiosis that have a restrictive defect because of coal workers' pneumoconiosis, there is a distinctly abnormal chest x-ray. I do not believe that this gentleman's shortness of breath is related to coal workers' pneumoconiosis. Rather, I think it is a combination of chronic obstructive lung disease secondary to smoking, exogenous obesity and cardiomegaly with probably some element of heart failure.

Dr. David Rosenberg (EX 5, 6)

Regarding the Claimant's impairment, Dr. Rosenberg stated the following:

> [E]ven if [the Claimant] was assumed to have a low-grade type of parenchymal abnormality (simple CWP) related to past coal dust exposure, an associated ventilatory impairment generally would not be expected. This fact is all (sic) supportive of the conclusion that his moderate reduction of TLC relates to "extrinsic factors," specifically his dialysis, as noted above, and his excessive weight. Obesity also clearly is known to cause this type of restrictive phenomenon. Any impairment [the Claimant] has does not relate to the presence of CWP. Also, one should appreciate that…the functional definition of COPD is a decrease in FEV_1 divided by FVC, also termed FEV_1%. With respect to [the Claimant, since his FEV_1% is normal, he does not meet the functional definition of COPD. Thus, he does not have the legal form of coal worker's (sic) pneumoconiosis (CWP).

Discussion

All of the physicians voiced an opinion on whether the Claimant had a respiratory impairment, and the nature of that impairment. I find that all of the physicians opined that the Claimant had a respiratory impairment; however only Dr. Hawkins made an opinion on whether the pneumoconiosis was disabling. Dr. Hawkins opined that the impairment left the Claimant "unable to perform manual labor or last coal mine job." Further, attached to Dr. Hawkins' opinion was a listing of the Claimant's coal mine employment, therefore, presumably Dr. Hawkins was aware of the Claimant's coal mine work history.

While the other two physicians spoke in terms of the Claimant having an impairment, specifically a restrictive defect, they did not state the extent of that impairment, or whether that impairment was disabling. Therefore, as Dr. Goldstein and Dr. Rosenberg did not state their opinion on the Claimant's level of disability, the record contains only one opinion relevant to the issue of total disability—that of Dr. Hawkins.

Based on the opinion of Dr. Hawkins that the Claimant is "unable to perform manual labor or last coal mine job," as well as the qualifying pulmonary function test results, I find that the Claimant has established by a preponderance of the evidence, that he is totally disabled due to a respiratory or pulmonary condition.

d. Whether the Claimant's Disability is Due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c); Consolidation Coal Co. v. Williams, 453 F.3d 609 (4th Cir. 2006); Consolidation Coal Co. v. Swiger, 98 Fed. Appx. 227 (4th Cir. 2004)(unpublished); Grundy Mining Co. v. Flynn, 353 F.3d 467 (6th Cir. 2004); Lollar v. Alabama By-Products Corp., 893 F.2d 1258 (11th Cir. 1990). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. In general, the fact that an individual suffers or suffered from a totally disabling respiratory or pulmonary impairment is not, in itself, sufficient to establish that the impairment is or was due to pneumoconiosis. § 718.204(c)(2). A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c).

The Benefits Review Board has held that a medical opinion that pneumoconiosis was one of two causes of a miner's total disability is sufficient to meet the "substantially contributing cause" standard. Gross v. Dominion Coal Corp., BRB No. 03-0118 BLA (Oct. 29, 2003). Likewise, the Board has held that a physician opinion that coal workers' pneumoconiosis was one of two causes of a miner's totally disabling respiratory impairment was sufficient to satisfy the causation requirements of 718.204(c)(1). Tapley v. Bethenergy Mines, BRB No. 04-0790 BLA (May 26, 2005). Therefore, there is no requirement that coal workers' pneumoconiosis be

the sole cause of the Claimant's totally disabling respiratory or pulmonary impairment. See Gross supra, see also Tapley, supra.

Discussion

As discussed above, all of the physicians opined that the Claimant had some respiratory impairment, however, they had differing opinions on the cause of that impairment. Dr. Hawkins attributed the impairment to in part to pneumoconiosis, COPD due to coal mine dust and smoking, and CAD, while Dr. Goldstein attributed the impairment to COPD "secondary to smoking, exogenous obesity and cardiomegaly with probably some element of heart failure," and Dr. Rosenberg opined the impairment was due to the Claimant's "dialysis…and his excessive weight."

Dr. Goldstein and Dr. Rosenberg opined that the Claimant did not have evidence of pneumoconiosis; therefore, they could not have found that pneumoconiosis was a contributing cause of his impairment. However, I found that the evidence did establish that the Claimant has pneumoconiosis. Their opinions are contrary to my findings on the record as a whole, and therefore I give their opinions on this matter little weight. See Toler v. Eastern Assoc. Coal Co., 43 F.3d 109 (4th Cir. 1995).

Dr. Hawkins was the physician who gave an opinion on whether the Claimant's impairment disabled him from his last coal mine employment, and the only physician who opined that the Claimant had pneumoconiosis. Further, he was the only physician to attribute any impairment to the Claimant's coal mine employment. Moreover, while Dr. Rosenberg attributed the Claimant's impairment to his dialysis, Dr. Hawkins was also aware of the Claimant's kidney problems and that the Claimant was on dialysis. However, despite these kidney problems, Dr. Hawkins still attributed the Claimant's impairment to pneumoconiosis. Given that the other two physicians opined that the Claimant did not have pneumoconiosis, given that his other opinions in this matter were consistent with my findings of the record as a whole, and given that I found his opinion reasoned and documented, I grant Dr. Hawkins' opinion significant weight.

After considering the physician opinions discussed above, I find that the Claimant has established by a preponderance of the evidence, based on physician opinion that his respiratory or pulmonary impairment is due to his pneumoconiosis.

IV. DATE OF ONSET

Benefits are payable to a miner who is totally disabled due to pneumoconiosis beginning with the month of onset of disability. Where onset cannot be determined, benefits commence with the date the claim was filed. § 725.503(b). I find that the evidence of record does not establish the date of onset of the Claimant's disability. Therefore, benefits shall commence in May 2005, the month and year in which the claim was filed.

V. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has established his entitlement to benefits under the Act.

VI. ATTORNEY'S FEE

No award of attorney's fees for services to Claimant is made herein because no fee application has been received. Thirty (30) days is hereby allowed Claimant's representatives for the submission of a fee application. A service sheet showing that service has been made upon all parties including Claimant must accompany the application. Parties have ten (10) days following receipt of any such application within which to file any objection. The Act prohibits the charging of a fee in the absence of an approved application.

VII. ORDER

The Claimant's Claim for benefits under the Act is AWARDED.

A

Adele H. Odegard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).